La Familia HEALTH

PATIENT REGISTRATION FORM (Please Print)

Today's Date: _____ **eCW Account Number**: _____

Patient's Demographic Information:

Last Name: _____ First Name: _____ MI: ____

Address: _____

City: _____ State: _____ Zip Code: _____ Do you live in Santa Fe County? Yes ☐ No ☐

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Ext. _____

Cell Phone: _____-_____-_____ Date of Birth: _____/_____/_____

Birth Sex:	**Sexual Orientation**:	**Gender Identity**:
☐ Male	☐ Lesbian, gay or homosexual	☐ Male
☐ Female	☐ Straight or heterosexual	☐ Female
☐ Unknown	☐ Bisexual	☐ Female-to-Male
	☐ Do not know	☐ Male-to-Female
	☐ Choose not to disclose	☐ Genderqueer
		☐ Choose not to disclose

Marital Status: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widow ☐ Legally Separated

Email Address:_____

_____I agree to use my email address for access to La Familia Health's Patient Portal, which allows secure viewing of my records and communication with staff. I agree to protect my password from any unauthorized users. I will notify La Famila Health should my password be compromised. I agree not to hold La Familia Health responsible for any network infractions beyond their control

Employment Status: (**please circle one)** 1= Employed Full Time 2 = Employed Part time 3 = Not Employed
4 = Self-employed 5 = Retired 6 = On Active Military Duty

Employer Name: _____

Student Status: F = Full Time P = Part Time N = Non Student

Responsible Party Information:

Self ☐ Guarantor ☐ (is guarantor a LFMC patient?) Yes ☐ No ☐

(Please complete Responsible Party's Information below)

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Ext. _____

Emergency Contact:

Last Name: _____ First Name: _____ MI: ____

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Ext. _____

Would you like the emergency contact person to have access to your medical information (HIPAA)? Yes ☐ No ☐

If you were prescribed medication today, which pharmacy would we send the prescription to:

Pharmacy Name: _____ Location: _____
If you are given a prescription and require a refill, contact your pharmacy directly at least 4-5 business days before you run out of medication. Your pharmacy will contact us.

Insurance Information:

Insurance Name: _____ Telephone Number _____ - _____ - _____

Insured's Name: _____ Relationship to Patient: _____

IS TODAY'S VISIT RELATED TO A WORKERS COMPENSATION CLAIM? YES _____ NO _____

Authorization to Release Information to Insurance

I authorize La Familia Health to release any medical/dental or other information that may be necessary for the completion of insurance claims, review of services or receipt of benefits to third party payers, the third party payer's agent and/or representative, payers, the third party payer's agent and/or representative. In addition, I authorize La Familia Health to bill my insurance for services rendered.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYMENT, CO-INSURANCE OR ANY OTHER PATIENT RESPONSIBILITY AMOUNTS THAT ARE NOT COVERED BY MY INSURANCE

Patient's Signature: _____ Date: _____/_____/____

Patient Representative Signature: _____ Date: _____/_____/____

Relation to Patient: _____

Additional Information:

Please select appropriate "Race" box below:	**Please select appropriate "Ethnicity" box below:**	**Please select appropriate "Language" box below:**	**Income Verification**
☐ Black or African American ☐ White ☐ Other (Please Specify) _____ ☐ Declined to Specify	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report	☐ English ☐ Spanish ☐ Other (please specify) _____	Approximate Weekly Household Income: $ _____ How many people live in your house including yourself _____

Are you a: Veteran ☐ Yes ☐ No Seasonal Farmer ☐ Yes ☐ No	**Do you have an Advance Directives?** Yes ☐ No ☐ Minor ☐ Do you have a Legal Guardian/Primary Care Giver? Yes ☐ No ☐ Name of Legal Guardian/Care Giver _____
Homeless ☐ Yes ☐ No **If yes…….** ☐ Transitional Housing ☐ At Risk of Homeless ☐ Street ☐ Homeless Shelter ☐ Doubling Up ☐ Other _____	**How did you hear about La Familia Health? Please check all that apply.** ☐ Newspaper Ad ☐ Radio Ad ☐ Social Media ☐ Referred by another agency or Doctor ☐ From a Friend or Family Member ☐ Other ☐ Brochure or Poster

YOUR RIGHTS AND RESPONSIBILITIES

- ✓ **NOTICE OF PRIVACY PRACTICES.** We are committed to keeping your protected health information safe and secure. I have received a copy or have been given the opportunity to review La Familia Health's Notice of Privacy Practices.
- ✓ **PATIENT COMPLAINT AND GRIEVANCE PROCEDURE.** I have received a copy or have been given the opportunity to review La Famila Health's Patient Complaint Procedure.
- ✓ **RIGHTS & RESPONSIBILITIES.** I have received a copy or have been given the opportunity to review La Famila Health's Patient Rights & Responsibilities.

APPOINTMENTS

- ✓ **APPOINTMENT DATE**. When you schedule an appointment with one of our providers that date and time is reserved exclusively for you to discuss and review your medical concerns. We therefore request that if you are unable to keep your scheduled appointment that you notify us 24 hours in advance so that the time might be made available to another patient or you will be considered a no show.
- ✓ **NEW PATIENT NO SHOW** - A new patient who no-shows twice in a row for a scheduled appointment will not be given another appointment for a period of one year.
- ✓ **ESTABLISHED PATIENT NO SHOW** – An established patient who no-shows three times within a year will not be given another appointment for a six-month period.
- ✓ **APPOINTMENT TIME** – Patients who are more than ten (10) minutes late will lose their appointment time and will need to reschedule.
- ✓ **AFTER-HOURS -** If you require after hour services you can call 505-982-4425, our Answering Service will put you in touch with the La Famila Health Provider on call. You can also go to the nearest Emergency Room.

CONSENT FOR TREATMENT AND OPERATIONAL USE OF CLINICAL RECORDS

- ✓ I consent to medical/behavioral health/dental treatment by the providers and clinical staff of La Familia Health for myself or for the patient for whom I am the parent or legal authorized representative. I authorize La Familia Health medical providers/behavioral health/dental providers and other clinic personnel, to administer such medications and to carry out examinations and diagnostic procedures that may be deemed necessary and/or advisable for my health care/behavioral health care/dental health care. The services/procedures mentioned beforehand may be performed at times by health professionals-in-training under supervision of health professionals employed by La Familia Health.
- ✓ If recommended by my medical or behavioral health provider, I consent to participate in telehealth services for care, treatment and services deemed necessary and have signed Telehealth Informed Consent Form.
- ✓ If applicable to my care and treatment, I consent to use of substance use disorder records by La Familia for healthcare operational uses, and if I consent, for billing purposes. I understand that these records cannot be used in a criminal investigation, criminal proceedings, or administrative and civil proceedings without my consent or court order.

FEES FOR YOUR CARE

- ✓ **INSURANCE.** We accept most insurances, including Medicare and Medicaid. We also collaborate with the New Mexico Department of Health, Title X to provide some services at minimum or no cost to the patient. Services such as women's health and birth control.
- ✓ **SLIDING FEE**. We offer a sliding-fee scale to make our services more affordable to patients who are income eligible. I understand that I have 30 days from the date of service to become eligible for the sliding fee. In order to be eligible I must provide LFH with proof of income for all working members of the household. Sliding fee eligibility will be based on family size and gross income. Should I fail to provide proof of income within 30 days I understand that I will be responsible for 100% of charges. La Familia Health operates within HRSA program requirements.
- ✓ I understand that I am responsible for any deductible, co-payment, co-insurance, or any other patient responsibility amounts that are not covered by my insurance or programs that I am eligible for.
- ✓ **I understand that there could be additional fees if other services are provided such as labs or procedures.**

Patient Name:_____

Patient Signature: _____ Date: _____
(or Parent/Legal Guardian if patient is under 18 years old)